Alaska Early Intervention / Infant Learning Program

Individualized Family Service Plan (IFSP)

Section 1 – Referral Information

Referral information

Child's First Name:_____ Last Name: _____

Child Previous Name or Alias: _____

Gender: ☐ Female ☐ Male Birth Date: _____

Referral Date:_____ 45-Day Deadline: _____

Referral Source: _____ Phone:_____

Referral Source Follow Up Date: _____ ☐ letter ☐ call

If parent is referral source, how did parent hear: _____

Reason for Referral: ☐ Eligibility Unknown ☐ Suspect non-Part C Eligibility ☐ Suspect Part C Eligibility

Referral Notes (include any important notes):

Child Living Situation: _____

Parent/Guardian Information (primary contact)

Name:_____ Relationship: _____

Mailing Address: _____

Physical Address: _____

Telephone: _____ Cell/Other Phone:_____

Email Address:_____

Additional Contact Name: _____

Family Service Coordinator Name:_____ Phone: _____

Name of person completing Referral Form:_____

Office Use Only:

Referral Disposition: ❑ Schedule Screen ❑ Screen Pending/Family Reasons ❑ Schedule Multidisciplinary Evaluation
❑ Evaluation Pending/Family Reasons ❑ Schedule IFSP Meeting ❑ Deceased
❑ Lost to Follow Up ❑ Decline Further Services

Section 2 – Child Information at Intake (complete within 45 days of referral)

Intake Date: _____ Person(s) completing intake: _____

Languages in Home: Primary _____ Other _____

Need for Interpreter ☐ Yes ☐ No Type of interpreter needed: _____

Child Ethnicity – Hispanic ☐ Yes ☐ No

Child Race (list all that apply): ☐ American Indian or Alaska Native ☐ Black or African American

☐ Asian ☐ Hawaiian or Other Pacific Islander ☐ White

Child typically spends the day with:_____

Child in Child Care ☐ Yes ☐ No Child Care Provider or Center:_____

Other family members in the household:

Name/relationship: _____Age: _____

Name/relationship: _____Age: _____

Name/relationship: _____Age: _____

Name/relationship: _____Age: _____

Other Important person/people in child's life: _____

If Child a ward of the state:

Surrogate Parent Name: _____ Phone: _____

OCS Social Worker Name: _____ Phone: _____

Insurance Information

Insurance Type (check all that apply):

☐ Private Insurance ☐ Self Pay ☐ SSI ☐ Medicaid/DKC/TEFRA
☐ IHS ☐ HCPCSN ☐ TRICARE ☐ HCB Waiver

Insurance Provider: ____ _____

Insurance Provider Address: ___ _____

Insurance Group Number (if applicable): _____

Medicaid Number (if applicable):_____

Child Social Security Number (if applicable):_ _____

Payment Agreement Completed ☐ Yes ☐ No

Parent has signed ILP Consent to Bill form ☐ Yes ☐ No

Child Physical Health/Medical Information

Primary Provider Type (Medical Home):
☐ Community Health Aide ☐ Family Practitioner ☐ No Medical Home ☐ Nurse Practitioner
☐ Other _____ ☐ Pediatrician ☐ Physician Assistant ☐ Public Health Nurse

Primary Provider Name: _ _____ Primary Provider Phone: _____
Primary Provider Address: _____ City: _____ State: __ __ Zip:__ ___

Gestational Age: _____ Birth Weight: __ ____

Did your child fail the newborn hearing screen? ☐ Yes ☐ No

Medical Diagnosis (list all that apply):

Medical Diagnosis verified by Doctor Report ☐ Yes ☐ No
Current Medical Records reviewed ☐ Yes ☐ No

Child Physical Health/Medical Information (Health Concerns)	**Source** (Screen, medical report, or parent report)	**Date** (of source, last screen or report)	**Describe Concerns or needs** (include NA if no concerns)
Vision			
Hearing			
Immunization			
Dental			
Behavioral health			
Medication(s)			
Nutrition			
Other			

Tell us about your pregnancy; did you experience any challenges?

Are there things (environmental or biological risk factors) that you're concerned might affect child's health or development?

Would you like more health and/or child development information? ☐ Yes ☐ No (If yes, please list):

Section 3.1 – Eligibility Evaluation Summary (complete within 45 days of referral)

Narrative Summary and Recommendations (Evaluation Notes) Date: _____

Developmental Skill Area (Domains)	Tool: Child Age:	Tool: Child Age:	Tool: Child Age:
	Score	Score	Score
Adaptive (self help)			
Cognitive			
Communication - Receptive			
Communication - Expressive			
Fine Motor			
Gross Motor			
Social Emotional			
Other			

Report Preparer Name: _ _____ Signature: _____

Office Use Only:

Evaluation Disposition: ❑ Enroll ❑ Continue Enrollment ❑ Enrollment Pending/Family Reasons
❑ Schedule Repeat Evaluation ❑ None – Within Normal Limits ❑ Lost to Follow Up
❑ Decline Further Services ❑ Deceased ❑ Waiting for Services ❑ Exit

Section 3.2 – Eligibility Determination for Part C Services (complete within 45 days of referral)

Date of Determination: ___ _____

☐ Child is **eligible for Part C** Services Parent initial: _____ Date:_____
(check one or more below and describe reason for determination under Narrative Summary above)

☐ **Developmental Delay** of at least 50% in one or more developmental domain.
☐ **Diagnosed Medical Condition** that is likely to result in a 50% delay.
☐ **Informed Clinical Opinion** The IFSP team believes this child has at least a 50% delay in one or more developmental domains without evaluation scores to support it.

☐ Child is **eligible for Non-Part C** Services as funding permits. Parent initial: _____ Date:_____

☐ Child is **not eligible** for Early Intervention Services. Parent initial: _____ Date:_____

☐ Child is **eligible and I decline** services. Parent initial: _____ Date:_____
The benefits of early intervention have been explained to me.

Multidisciplinary Evaluation Team Signature

(The IFSP multidisciplinary team must include the parent and at least two individuals from separate disciplines or professions, and one of these individuals must be the service coordinator.)

Multidisciplinary Evaluation/Assessment Team and or Resources			
Discipline	Printed Name	Signature (if present)	Date

Family Rights

Alaska's Early Intervention/Infant Learning Program has prepared a resource for all parents & guardians of infants and toddlers with disabilities regarding their family rights to special needs services under the Individuals with Disabilities Education Act (IDEA). Your Early Intervention/Infant Learning Program provider will help you understand these rights. Please take a moment to review these rights in the Alaska Early Intervention/Infant Learning Program Child and Family Rights Booklet with your provider at this time.

Section 4 – Family Assessment: Concerns, Priorities and Resources (start within 45 days)

Using the information from the family assessment, list the family's main concerns and priorities (items to address in IFSP goals) for the child and family. *Please note "family declines" if the family does not want to participate in a Family Assessment.*

Using the information from the ecological map, RBI or other family assessment tool, list the family supports and resources.

Section 5.1 – Summary of Child's Present Abilities, Strengths and Needs

(To be completed within 90 days of enrollment, at annual IFSP and within 90 days of exit.)

All developmental domains *(Adaptive, Cognitive, Communication, Fine and Gross Motor, and Social Emotional)* should be considered when describing the child's current functional behaviors in the following areas.

What are the child's abilities, strengths and needs pertaining to social emotional skills, including positive social relationships?

What are the child's abilities, strengths and needs pertaining to acquiring and using knowledge and skills?

What are the child's abilities, strengths and needs pertaining to taking appropriate actions to meet needs?

Section 5.2 – Child Outcome Summary Ratings

Rating Date: _____ *(To be completed within 90 days of enrollment, at annual IFSP and within 90 days of exit. Note: for an infant enrolled before 3 months of age, the initial rating may be completed no later than six months of age)*

Sources of supporting evidence *(Choose all that apply)*	**Date**	**Description/comments**
Anchor Tool		
Other Assessment Tool(s)		
Evaluation Report(s)		
Parent Report/Interview		
Observation(s)		

To what extent does the child show age appropriate functioning in each of the following outcome areas across a variety of settings and situations? *(Please refer to Section 5.1 Summary of Child's Present Abilities, Strengths and Needs to inform the ratings).* *Use the rating scale below*

1. Positive social-emotional skills — Rating: ☐
2. Acquiring and using knowledge and skills — Rating: ☐
3. Taking appropriate actions to meet needs — Rating: ☐

Rating scale: not yet <emerging emerging <somewhat somewhat <completely completely

Outcome Progress

Has the child shown any new skills or behaviors related to the three outcome areas below, since the last child outcome summary?

1. Positive social-emotional skills ☐ Yes ☐ No
2. Acquiring and using knowledge and skills ☐ Yes ☐ No
3. Taking appropriate actions to meet needs ☐ Yes ☐ No

Describe progress since last rating:

Name of persons involved in child outcome rating	Role

Section 6.1 – IFSP Goals for CHILD (start within 45 days)

IFSP Goals are based on the child's needs/interests and family routines and priorities. Goals must be written in the primary language that is understood by all IFSP team members, including the family.

Goal # ___ Date: _____

Child Outcome: ❑ Social-Emotional Skills ❑Acquiring Knowledge & Skills ❑Taking Action to Meet Needs

What the IFSP team would like the child to be able to do in the next few months *(Functional, achievable, and meaningful)*.

How will we know we've achieved the goal? *(Measurable/Criteria: Progress statement must be measured within the context of everyday learning activities.)*

To achieve this, we will? *(Strategies to take place in the context of everyday routines*)

Who will be helping achieve this goal?

How did we do? *(Progress Statement – Check appropriate box)*

Date	Achieved	Continue	Revise	Discontinue	Comments

Section 6.2 – IFSP Goals for FAMILY (start within 45 days)

Family goals are based on your concerns and what your family would like to work on. Think back to the list of concerns you expressed for your family and child. The following goal(s) will help us decide what services and strategies are needed to help you address your main concerns.

Goal # _____ Date: _____

What do you want to accomplish in the next few months with your child or family.

How will we know we've achieved the goal? *(Criteria/Measurable statement)*

To achieve this, we will? *(What will happen or supports are needed to help your family achieve the goal.)*

Who will be helping achieve this goal?

How did we do? *(Check appropriate box)*

Date	Achieved	Continue	Revise	Discontinue	Comments

Section 7 – Summary of Services [34 CFR§§303.344]

Date of this IFSP Meeting	**Early Intervention Service** (Service type)	**Persons/Agency Responsible** (Provider)	**Service Status** Initiate, continue, discontinue)	**Start Date**	**Duration** (how long the service is needed: 1, 3, 6 months, etc)	**Length** (Total units per contact)	**Frequency** (how often)	**Intensity** (group or individual)	**Method** (How provided: ILP Provider or contractor, Needed unavailable, other	**Location** (program setting)	**Method of Payment** (private insurance, Self pay, SSI, Medicaid, HIS, HCPCSN,
	Other Services (not ILP Provided)										

Early Intervention Service Type:

1. Assistive Technology
2. Audiology Services
3. Health Services
4. Medical/Diagnostic
5. Nursing Services
6. Nutrition Services
7. Occupational Therapy
8. Physical Therapy
9. Psychological Services
10. Service Coordination
12. Social Work
13. Special Instruction
14. Speech Language Therapy
15. Transportation
16. Vision Services
17. Family Training /Support

Frequency: 0.25 - Annually, 0.5- twice a year, 1- quarterly, 12- weekly, 3-monthly, 6- twice per month, 9- 3 times a month

Location: Home, Community, Other

Parent/Guardian Decline Recommended Services

❑ I decline the following recommended services:

Early Intervention Service	Parent Initial	Date

IFSP team justification as to why the following services are not in the natural environment:

Service	Location	Justification

Strategies to move toward providing Service(s) in everyday routines, activities, and places:

Section 8.1 – Transition Plan

Date of Child's 3rd Birthday: _____

Date of this Transition Plan: _____ Transition Conference Due Date: _____

Age	Transition Planning Activity (Recommended priorities and goals for child's transition) Indicate "NA" for activities not applicable for individual child/family transition.	Person(s) Responsible	Due Date	Date Completed
By 27 months	• Provide notification information to parent/guardian. • Obtain opt out form if parent/guardian opts out of notification to local school district.			
24-30 months	• Introduce Steps Ahead booklet. • Discuss potential service settings. • Explain parent/guardian rights and procedural safeguards. • Obtain parental consent to invite staff/people as appropriate (preschool special education, child care, Head Start, etc) to Transition Conference meeting. • Complete referral/applications as appropriate (preschool special education, child care, Head Start, etc).			
30-33 months	• Schedule and hold Transition Conference. • Schedule or complete necessary evaluations. • Schedule family visits to new setting (preschool special education, child care, Head Start, etc) if possible. • Provide current IFSP, evaluation reports and progress notes to transition planning team, with signed parent consent/release of information.			
33-36 months	• Attend eligibility meeting upon invitation, assist in determining eligibility as necessary. • Decide on placement/program and start date for child. • Attend IEP meeting upon invitation if going on to special education setting. • Complete activities/visit to prepare child for transition. • Complete exit summary			

Notes:

Section 8.2 Transition Conference

The purpose for this meeting is to discuss what is important to you and your child in a new setting, identify goals to prepare your child for transition and gather additional helpful information.

Date of Child's 3rd Birthday: _____ Meeting Date _____

Was the transition conference held at least 90 days prior to child's 3rd birthday? ☐ Yes ☐ No

If No, indicate category and provide explanation.

☐ Provider circumstances ☐ Family circumstances ☐ ILP agencies circumstances

Options for placement/program/services (Head Start, Special Education Preschool, etc)**:**

Summary of current services and needs:

Next Steps (How we will prepare for transition to the next placement)	**Person(s) Responsible**	**Start Date**	**Date Completed**

Section 9 – IFSP Meeting Signatures

The IFSP must be reviewed at least every 6 months and revised annually. Document progress in achieving outcomes based on current assessment information. IFSP Meeting Participants must sign this signature page.

IFSP Meetings	**Projected Date**
Six Month IFSP Review Date:	
Annual IFSP Renewal Date:	
Transition Planning Meeting Date:	

Date of this IFSP Meeting: _____

Type of IFSP Meeting: ❑ interim ❑ initial ❑ 6 month review ❑ annual ❑ periodic revision ❑ transition

Consent by Parent/Guardians for Provision of Services

❑ I give informed consent for this Individualized Family Services Plan (IFSP) to be carried out as written.
Parent/Guardian Initials _____ Date: _____

Printed Name	Signature (if present)	Role/Title	Phone or Email Contact *(optional)*